ZURICH

Sleep disorder questionnaire

This form is to be completed only on request by Zurich Underwriting. To be completed by the life insured. To avoid delays, please check that all questions have been answered fully. Please use BLOCK LETTERS.

Policy number/s ______________________

Policy type: ☐ Wealth Protection ☐ Active ☐ Sumo ☐ FutureWise

Duty to take reasonable care not to make a misrepresentation

Your duty to take reasonable care not to make a misrepresentation is explained in the PDS and the Life Insured's Statement and it applies each time you provide us with information before we issue a policy.

Not meeting your legal duty can have serious impacts on your insurance. Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). In completing the forms or questions herein you will be providing us with your personal and, perhaps, sensitive information. The collection and management of this information is governed by the Privacy Act 1988. For a more detailed explanation of Zurich's Privacy Policy please visit our website at www.zurich.com.au or contact the Zurich Privacy Officer on 132 687 or email us at privacy.officer@zurich.com.au.

1 Life insured details

Title Surname

Given names Date of birth / /

Address State Postcode

Contact details Work ( ) Home ( )

Mobile Email

2 Sleep disorder details

(a) What is the condition/diagnosis? Date diagnosed / /

(b) Have you ever undertaken a sleep study?

☐ Yes ➞ when was this last completed? / /

what was the reported severity? ☐ Mild ☐ Moderate ☐ Severe ☐ Unsure

☐ No ➞ Have you been advised to undertake a sleep study?

☐ Yes ➞ confirm if and/or when this will take place / /

☐ No ➞ clarify on what basis were you diagnosed with sleep apnoea (such as symptoms, etc.)

(c) What symptoms did you experience? (common symptoms may include choking or gasping on waking from sleep, daytime fatigue and tiredness, morning headaches, falling asleep during the day, heavy snoring, or choking/breathing cessation during sleep)

(d) Do you still experience these symptoms?

☐ Yes

☐ No ➞ when did you last experience these symptoms? / /

ZU23426 - V3 08/21 - TKAE-017391-2021

2 Sleep disorder details (continued)

(e) Are you currently receiving treatment for this condition?

☐ Yes → what treatment are you receiving? ☐ CPAP ☐ Mandibular splint/Mouthguard ☐ Other

have you been advised that this treatment is effective in treating your condition?

☐ Yes

☐ No

☐ No → have you ever been treated, or been recommended to receive treatment?

☐ No

☐ Yes → provide details, including date ceased if appropriate

(f) Have you ever required time off work, or been restricted in your work duties and/or lifestyle due to this condition?

☐ No

☐ Yes provide details

(g) Who was, or is your current treating doctor for this condition?

Doctor's/Clinic's name

Address State Postcode

Phone number

Dates consulted From / / Most recent / /

(h) Have you consulted any other health professions for the condition/s? Yes ☐ No ☐ If 'Yes', provide details below

Doctor's/Clinic's name

Address State Postcode

Phone number

Dates consulted From / / Most recent / /

3 Declaration

The proposed life insured states as follows:

1. I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
2. I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.
3. I acknowledge that Zurich will rely on statements in this questionnaire in deciding whether to issue an insurance policy and what terms and premium to offer.
4. I authorise Zurich to disclose any information in relation to my application for insurance to any person for the purpose of assisting Zurich to make a decision in relation to my application for insurance.
5. I understand that the insurance applied for shall not become effective until Zurich accepts my application.
6. I authorise my medical practitioner or other professional (i.e. accountant) to disclose any information that they may possess about me to Zurich in relation to my application for insurance or any claim under it.
7. I authorise Zurich to approach any person named in this questionnaire to verify any aspect. In the same way, I authorise any person named in my questionnaire to disclose any information they may possess about me to Zurich.

Name of life insured

Signature of life insured Date

✗ / /

Any questions? Call 131 551

Please return the completed form to us:

By post, to **Zurich Australia Limited, Underwriting Department, Locked Bag 994, North Sydney NSW 2059**, or

By email, as a scanned attachment, to **life.newbusiness@zurich.com.au**

Save File Print Form